MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9727 — 09696

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 Wk
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 810 Camden Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ESTHER Middle McNEILL Last Bailey

4. DATE OF DEATH: Month August Day 25 Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-6-1880
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John McNeil
14. MOTHER'S MAIDEN NAME: Susan Reid

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. R. Herman Hodgson, Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Arteriosclerotic Heart Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/20/55 19 to 8/25/60 19, that (I) (we) last saw the deceased alive on 8/25/60 19, and that death occurred at 4:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: A. C. Mitchell M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-27-1960
22c. PHYSICIAN'S NAME (Type): Dr. Andrew C. Mitchell
22d. ADDRESS: 211 Maryland Ave., Salisbury

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-30-1960
23c. NAME OF CEMETERY OR CREMATORY: St. Philips Cemetery
23d. LOCATION (City, town, or county) (State): Quantico, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hill & Johnson Co. Salisbury, Maryland
25a. REC'D BY REGISTRAR DATE: AUG 31 '60
25b. REGISTRAR'S SIGNATURE: Carlton L. Kenna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9728

09697

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 3 WEEKS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): POCOMOKE CITY
d. STREET ADDRESS: 403 WALNUT STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle NEALY Last BAILEY

4. DATE OF DEATH: Month AUGUST Day 21 Year 1960

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCTOBER 6, 1883

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): POLICEMAN

10b. KIND OF BUSINESS OR INDUSTRY: POCOMOKE CITY POLICE DEPARTMENT

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: SEWELL H. BAILEY

14. MOTHER'S MAIDEN NAME: CLARA NORTHAM

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 213-10-3994

17. INFORMANT: MRS HATTIE V. BAILEY, Address 403 WALNUT ST. POCOMOKE CITY, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 Days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cerebral Arteriosclerosis
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 31 1960 to Aug 21 1960 that (I) (we) last saw the deceased alive on Aug. 20 1960 and that death occurred at 7:A M, from the causes and on the date stated above.

22a. SIGNATURE: David J. Gilmore M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/21/60

22c. PHYSICIAN'S NAME (Type): DAVID J. GILMORE, M. D.

22d. ADDRESS: SALISBURY, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 8-24-60

23c. NAME OF CEMETERY OR [redacted]: UNION GREENBACKVILLE

23d. LOCATION (City, town, or county) (State): WORCESTER COUNTY, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Henry H. Watson ADDRESS: POCOMOKE CITY, MD.

25a. REC'D BY REGISTRAR DATE: AUG 25 '60

25b. REGISTRAR'S SIGNATURE: Cortina S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9729

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09698

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
d. STREET ADDRESS: Route # 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Otho — Middle: — Last: Barnes

4. DATE OF DEATH: Month: 8-5-60 — Day — Year: 19

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-22-1910

9. AGE (In years last birthday): 49 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Norfleet Barnes

14. MOTHER'S MAIDEN NAME: Ada Barnes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Alice Barnes, Berlin, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Broncho-pneumonia-	3 days
DUE TO (b)	Acute methyl alcohol poisoning-	3 days
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 8-11-60

EXAMINER'S NAME (Type): Earl L. Royer, M.D. — Address (Street, town, county): 407 Camden Ave. Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-10-60

22c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery

22d. LOCATION (City, town, or country) (State): Berlin, Md.

23. FUNERAL DIRECTOR: Thornton Jolley — ADDRESS: Salisbury, Md.

24a. REC'D BY REGISTRAR — DATE: AUG 15 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kines

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9773 — 09699

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Accomac
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New Church
d. STREET ADDRESS: Sta 83X-3
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First ANNIE Middle W. Last BONNEVILLE

4. DATE OF DEATH: August 22 1960

5. SEX: Female

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JAN. 22, 1905

9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: House-Work

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elizah MARSHALL

14. MOTHER'S MAIDEN NAME: mildred Broughton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 229-09-6313

17. INFORMANT: Address: James Marshall - New Church, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Failure — INTERVAL BETWEEN ONSET AND DEATH: 48 hours
592X
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
DUE TO (b): Uremia — ?
DUE TO (c): Chronic Nephritis — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Uterine Bleeding

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/17 1960 to 8/22 1960, that (I) (we) last saw the deceased alive an 8/22 1960, and that death occurred at 12 08 M, from the causes and an the date stated abave.

22a. SIGNATURE: Joseph C. Fitzgerald M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/28/60

23c. NAME OF CEMETERY OR CREMATORY: WARDTOWN

23d. LOCATION (City, town, or county) (State): Pocomoke Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Edgar Wharton - New Church, Va.

25a. REC'D BY REGISTRAR DATE: AUG 26 '60

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9771

09760

M

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Fruitland
c. LENGTH OF STAY IN 1b: 6 months
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Hayward Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Crisfield
d. STREET ADDRESS: Laird Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

1939-2

X

3. NAME OF DECEASED (Type or print): First HARRIETT — Middle EMMA — Last CATLIN

4. DATE OF DEATH: Month August — Day 4 — Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 12, 1867

9. AGE (In years last birthday) 93 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Fairmount, Somerset- Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Revelle

14. MOTHER'S MAIDEN NAME: Nancy Bozman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-07-5969A

17. INFORMANT — Address: Mrs. Clarence Byrd--Hayward Ave.--Fruitland, Md.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary artery occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 min
DUE TO (b): generalized arteriosclerosis — ? yr.
DUE TO (c):

420.1

Conditions, if ony, which gove rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Haur a. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While at work ☐ Nat while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 1960 to Aug 1960 that (I) (~~we~~) last saw the deceased alive on 30 July 1960, and that death occurred at 3:15 AM, from the causes and on the date stated above.

22a. SIGNATURE: Robt T. Adkins M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6 Aug '60

22c. PHYSICIAN'S NAME (Type): ROBERT T. ~~William~~ Adkins, M. D.

22d. ADDRESS: Fruitland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug.6,1960

23c. NAME OF CEMETERY OR CREMATORY: Sunnyridge Cemetery

23d. LOCATION (City, town, or county) (State): Crisfield, Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Bradshaw & Sons--Crisfield, Md.

25a. REC'D BY REGISTRAR DATE: AUG 16 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9730

CERTIFICATE OF DEATH

09701

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 408 Stewart Pl.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 408 Stewart PL.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gladys — Middle: M. — Last: Collins

4. DATE OF DEATH: Month: August — Day: 2 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: Col.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Febuary 17, 1903

9. AGE (In years last birthday): 57 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Bevans

14. MOTHER'S MAIDEN NAME: Levenia Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: George Collins — Address: 408 Stewart PL. Salis. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 min
DUE TO
(b): Arteriosclerotic Heart disease — 10 years
DUE TO
(c):

420.0

Conditions, if any, which gove rise to immediote cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cardiac decompensation

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 1960, to August 2, 1960, that I last saw the deceased alive on July 30, 1960, and that death occurred at 8 30 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L. V. Sohler M.D. — ADDRESS (Street, city or town, state): 303 East Street Delmar, Md. — DATE SIGNED: 10-8-60

PHYSICIAN'S NAME (Type): L. V. SOHLER M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/6/1960
22c. NAME OF CEMETERY OR CREMATORY: Glass Hill
22d. LOCATION (City, town, or county) (State): Parsonsburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Clinton F. Stewart — ADDRESS: Salisbury Md.

24a. REC'D BY REGISTRAR — DATE: AUG 15 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Timmons

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9731

09702

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1. **PLACE OF DEATH**
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 18 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hosp.

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 407 West Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: William — Middle: EDWARD — Last: Collins

4. **DATE OF DEATH**: Month: August — Day: 29 — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: NOV. 18, 1888

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): COOK

10b. KIND OF BUSINESS OR INDUSTRY: RESTAURANT

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: WILLIAM E. COLLINS

14. MOTHER'S MAIDEN NAME: SARAH A. COLBOURN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: UNKNOWN

17. **INFORMANT**: MRS Roy LESCEALLETTE, Address 906 CEDAR ST. Pocomoke, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic Staph Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO: and hemorrhagic Shock — 12 days
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b) DUE TO: Bleeding duodenal ulcer — ?

541.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, affice bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11 August 1960, to 29 Aug. 1960, that (I) (~~we~~) last saw the deceased alive on 28 Aug 1960 and that death occurred at 7:55 M, from the causes and on the date stated above.

22a. SIGNATURE: Robert T. Adkins M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 29 Aug 60

22c. PHYSICIAN'S NAME (Type): ROBERT T. ADKINS

22d. ADDRESS: FRUITLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 8-31-60
23c. NAME OF CEMETERY ~~OR CREMATORY~~: NELSON CEMETERY
23d. LOCATION (City, town, or county) (State): RURAL-POCOMOKE, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Robert H. Watson
ADDRESS: POCOMOKE, MARYLAND
25a. REC'D BY REGISTRAR DATE: SEP 2 '60
25b. REGISTRAR'S SIGNATURE: Clifton S. Thawley

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9732 Item 11 FilmG269 8-22-60 et

09703

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke
d. STREET ADDRESS: Route # 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

19X-2

3. NAME OF DECEASED (Type or print): First: Leona; Middle: ; Last: Cook

4. DATE OF DEATH: Month: August; Day: 8; Year: 1960

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1907

9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unk.

14. MOTHER'S MAIDEN NAME: Unk.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Address: Md.
Deer's Head State Hospital Records, Salisbury

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

422.1

DUE TO (b): Arteriosclerotic cardiovascular dis., decompensated — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Arteriosclerosis, general — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Residual left hemiplegia due to cerebral thrombosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August 2, 1960 to August 8, 1960, that (I) (we) last saw the deceased alive on August 8 1960, and that death occurred at 8:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: V. Juerman M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 8/9/60

22c. PHYSICIAN'S NAME (Type): V. Juerman, M. D.

22d. ADDRESS: Deer's Head State Hospital; Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY: Anatomy Board of Md.

23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR DATE AUG 18 '60

25b. REGISTRAR'S SIGNATURE: Clifford L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9772

CERTIFICATE OF DEATH

09704

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town): Springs S/HARPTOWN
c. LENGTH OF STAY IN 1b: 24 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MAPLE SHADE NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING 15342
d. STREET ADDRESS: 12612 FARNELL DR
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First MARY Middle WILSON Last CORNELL

4. DATE OF DEATH: Month AUG Day 8 Year 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: DEC 13 1872

9. AGE (In years last birthday): 87 yrs.

IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: John W.H. COOK

14. MOTHER'S MAIDEN NAME: ANNA COLEMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: MR ROWLEY CORNELL 12612 FARNELL DR. S.S.MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma - Colon — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO (b): 153.8
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 19 57, to Aug 8, 1960, that I last saw the deceased alive on Aug 8, 1960, and that death occurred at 2 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: H.S. Kuhlman M.D. ADDRESS (Street, city or town, state): Sharpstown Md DATE SIGNED: 8/10/60

PHYSICIAN'S NAME (Type): H.S. Kuhlman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug 11, 1960

22c. NAME OF CEMETERY OR CREMATORY: Firemen's

22d. LOCATION (City, town, or county) (State): Sharptown Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Smith Funeral Home Sharptown, Md

24a. REC'D BY REGISTRAR DATE: AUG 15 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9733 — 09705

1. PLACE OF DEATH — a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: South Carolina — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New Berry
d. STREET ADDRESS: XXX
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: LESTER — Middle: A. — Last: CROOKS

4. DATE OF DEATH: Month: August — Day: 27 — Year: 1960

5. SEX: FEMALE — 6. COLOR OR RACE: NEGRO — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: 6-4-1877 — 9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER — 10b. KIND OF BUSINESS OR INDUSTRY: FARM — 11. BIRTHPLACE (State or foreign country): South Carolina — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Vaugh Hood — 14. MOTHER'S MAIDEN NAME: Annie Hood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT — Address: Mrs. Jack Ayres, NEWARK, Md.

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertensive Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yr.
443X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factary, street, affice bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/21 1960 to 8/27 1960 that (I) (we) last saw the deceased alive on 8/27 1960, and that death occurred at 10:35 A.M. from the causes and on the date stated above.

22a. SIGNATURE: David J. Gilmore M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DAVID J. GILMORE — 22d. ADDRESS: Salisbury, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 9-4-60 — 23c. NAME OF CEMETERY OR CREMATORY: St. James Cem. — 23d. LOCATION (City, town, or county) (State): Pomaria S.C.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Thornton B. Jolley, Salisbuey, Md. — 25a. REC'D BY REGISTRAR DATE: AUG 30 '60 — 25b. REGISTRAR'S SIGNATURE: Clinton S. Kenne

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9774

CERTIFICATE OF DEATH

Reg. Dist. No. 09706

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 50 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Rt #5

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Salisbury
d. STREET ADDRESS: Rt #5
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Larry — Middle: Jerome — Last: Culver

4. DATE OF DEATH: Month: 8 — Day: 5 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-4-1888

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired General

10b. KIND OF BUSINESS OR INDUSTRY: Store Grocer

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Jerome F. Culver

14. MOTHER'S MAIDEN NAME: Mary Nicholson.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 214-36-5488

INFORMANT: Minnie C. Culver — Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Artery Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs
DUE TO (b): Coronary Atherosclerosis — 2 yrs
DUE TO (c): —

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour o. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 7/29, 1959, to 8/5, 1960, that I last saw the deceased alive on 8/5, 1960, and that death occurred at 10:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: David J. Gilmore, M.D. — ADDRESS (Street, city or town, state): Salisbury, Maryland — DATE SIGNED: 8-6-60

PHYSICIAN'S NAME (Type): David J. Gilmore Medical Center

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-7-1960

22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hill & Johnson Co. — ADDRESS: Salisbury, Md

24c. REC'D BY REGISTRAR DATE: AUG 8 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

Norman F. Baker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

69707

9734 Item-8 Film G269 8-29-60 et

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 300 Race St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SARAH Middle ELLEN Last DAWSON

4. DATE OF DEATH: Month AUGUST Day 19 Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 26, 1896 (1895)
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Garden S. Shockley
14. MOTHER'S MAIDEN NAME: Ida Cranfield

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Thomas J. Dawson (Husband) 300 Race St Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction
DUE TO (b): Hypertension & Degenerative Heart Disease
DUE TO (c): Arteriosclerosis

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.: N/A 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A
20f. (City or town) (County) (State): N/A

21. I certify that (I) (this hospital) attended the deceased from 8/15/60 a.m., 19__ to 8/19/60 a.m., 19__, that (I) (we) last saw the deceased alive on ____ 19__, and that death occurred at 7:15 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Dr Carrie Hearn M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug. 20 /1960
22c. PHYSICIAN'S NAME (Type): Dr. Carrie Hearn
22d. ADDRESS: N. Division St. Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 22, 1960
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City, town, or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY
ADDRESS: SALISBURY MARYLAND
25a. REC'D BY REGISTRAR DATE: AUG 23 '60
25b. REGISTRAR'S SIGNATURE: Irving L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9735 09708

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbary
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Olive Middle Bell Last Downes

4. DATE OF DEATH Month August Day 29 Year 1960

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Nov. 27, 1897
9. AGE (In years last birthday) 62 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shirt Factory
10b. KIND OF BUSINESS OR INDUSTRY Machine Operator
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George Baker
14. MOTHER'S MAIDEN NAME Ella B. Palmer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-05-6591
17. INFORMANT Mrs. Aaron Wilkins Address Willards, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct, acute — INTERVAL BETWEEN ONSET AND DEATH 1 day
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-29 1960, to 8-29 1960 that (I) (we) last saw the deceased alive on 8-29 1960, and that death occurred at 6:30 AM, from the causes and on the date stated above.

22a. SIGNATURE William R. Ellis Jr. M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 8-29-60
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 9-2-60
23c. NAME OF CEMETERY OR CREMATORY New Hope
23d. LOCATION (City, town, or county) (State) Willards Md.

24. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Shilyard ADDRESS
25a. RECD BY REGISTRAR Date SEP 6 '60
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9736

CERTIFICATE OF DEATH

Item 5 Film C268 8-8-60 et

Reg. Dist. No. 09709

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 57 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 10 CAMDEN Ave Ext

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
d. STREET ADDRESS: 10 CAMDEN Ave EXT
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First AMHERST — Middle — Last EATON

4. DATE OF DEATH: Month 8 — Day 2 — Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-27-1877
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NEWSPAPER, Ret
10b. KIND OF BUSINESS OR INDUSTRY: EDITORIAL
11. BIRTHPLACE (State or foreign country): MASS.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George EATON
14. MOTHER'S MAIDEN NAME: Lucy WASHBURN.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 298-05-6211
INFORMANT: Thomas C. Hill, Jr. — Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis
DUE TO (b): Cerebral Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Basal Cell Carcinoma of Face + Neck
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December, 1954, to Aug 2, 1960 that I last saw the deceased alive on August 2, 1960, and that death occurred at 5:00 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state)
DATE SIGNED 8/2/60
ACTUAL SIGNATURE: Thomas C. Hill, Jr. M.D.
PHYSICIAN'S NAME (Type) Thomas C. Hill, Jr. Pine Bluff Road, Salisbury

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8-5-1960
22c. NAME OF CEMETERY OR CREMATORY: OAK DALE CEM
22d. LOCATION (City, town, or county) (State): URBANA, OHIO

23. FUNERAL DIRECTOR'S SIGNATURE: Hill & Johnson Co.
ADDRESS: SALISBURY, MD
24a. REC'D BY REGISTRAR DATE: AUG 4 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9737 09710

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 1 MONTH
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: SOMERSET
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EWELL
d. STREET ADDRESS: 197-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle C. Lost EVANS

4. DATE OF DEATH: Month AUGUST Day 27 Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: AUG. 15, 1882

9. AGE (In yeors lost birthday): 78 yrs.
IF UNDER 1 YEAR: Months ___ Doys ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: BENJAMIN F. WHITNEY

14. MOTHER'S MAIDEN NAME: KATHRYN EVANS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT Address: MRS. LEON EVANS - 24 MAIN ST. - CRISFIELD, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Carcinoma of Urinary Bladder — INTERVAL BETWEEN ONSET AND DEATH: 12 mons.
DUE TO
(b):
Conditions, if any, which gave rise to immediate couse (o), stating the underlying couse last.
DUE TO
(c):
181.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 21 1960 to Aug. 26 1960 that (I) (we) last saw the deceased alive on Aug 26 1960, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Raymond M. Yow M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug. 27, 1960

22c. PHYSICIAN'S NAME (Type): RAYMOND M. YOW, M.D.

22d. ADDRESS: 707 Camden Ave. Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: AUG. 30, 1960
23c. NAME OF CEMETERY OR CREMATORY: EWELL CEMETERY
23d. LOCATION (City, town, or county) (State): EWELL MD.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: BRADSHAW & SONS, CRISFIELD, MD

25a. REC'D BY REGISTRAR DATE: SEP 6 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Price

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9738 — 09711

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 12
d. STREET ADDRESS: Cedar Way 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LILLIAN Middle PARDEE Last Fields

4. DATE OF DEATH: Month August Day 28 Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 29, 1905
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sewing Mach. Oper.
10b. KIND OF BUSINESS OR INDUSTRY: Shirt Fact.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alex W. Carey
14. MOTHER'S MAIDEN NAME: Minnie Hastings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 214-10-7800
17. INFORMANT: Sidney Fields Address: Cedar Way Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Glioma, temporal lobe — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
193.9

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-1 1960, to 8-28 1960 that (I) (we) last saw the deceased alive on 8-28 19(a), and that death occurred at 1:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE: William R. Ellis, Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-28-60
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-31-1960
23c. NAME OF CEMETERY OR CREMATORY: Methodist Washington Church Cem. "Shad Point"
23d. LOCATION (City, town, or county) (State): Salisbury, Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Thomas F. Walker Salisbury, Md.
25a. REC'D BY REGISTRAR DATE AUG 30 '60
25b. REGISTRAR'S SIGNATURE: Carlton E. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9739 — 09712

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 108 W. Isabella St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 108 West Isabella St

3. NAME OF DECEASED (Type or print): First ELLEN — Middle DALE (McMASTER) — Last FISHER

4. DATE OF DEATH: Month AUGUST — Day 5th — Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 22, 1880
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months 10 — Days 13
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Princess Anne, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William S. McMaster
14. MOTHER'S MAIDEN NAME: Ella Dale

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: E. McMaster Duer (Nephew) Address: Princess Anne, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 years
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year: N/A 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A
20f. (City or town) (County) (State): N/A

21. I certify that (I) (this hospital) attended the deceased from Dec 5 1958 to August 5 1960 that (I) (we) last saw the deceased alive on Aug 5 1960, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Wilber R. Ellis, Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: August 5 /1960
22c. PHYSICIAN'S NAME (Type): Dr. David J. Gilmore / Dr. Wilber R. Ellis, Jr.
22d. ADDRESS: Medical Center - Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 7, 1960
23c. NAME OF CEMETERY OR CREMATORY: Manokin Cemetery - Princess Anne, Maryland
23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY - WRH
ADDRESS: SALISBURY MARYLAND
25a. REC'D BY REGISTRAR DATE: AUG 8 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9740 Item 2 Film 271 9-15-60 et 09713

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
d. STREET ADDRESS: RFD --
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

23X-2

3. NAME OF DECEASED (Type or print): First LeRoy Middle W. Last Fisher

4. DATE OF DEATH: Month August Day 29 Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 30, 1917
9. AGE (If years lost birthday) 42 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mail Carrier
10b. KIND OF BUSINESS OR INDUSTRY: U.S.
11. BIRTHPLACE (State or foreign country): Berlin MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Fisher
14. MOTHER'S MAIDEN NAME: Margaret Zoillen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War II
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Mrs. L. W. Fisher — Address: Berlin MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Mesenteric Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b):
DUE TO (c):

570.2

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-27 1960 to 8-29 1960 that (I) (we) last saw the deceased alive on 8-29 1960, and that death occurred at 11 A.M. from the causes and on the date stated above.

22a. SIGNATURE: William B. Ellis M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-29-60
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 9/1/60
23c. NAME OF CEMETERY OR CREMATORY: EVERGREEN
23d. LOCATION (City, town, or county) (State): BERLIN MD.

24. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage — ADDRESS: Berlin Md.
25a. REC'D BY REGISTRAR DATE: SEP 1 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9741

CERTIFICATE OF DEATH

09714 Reg. Dist. No.

1 -

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1

1. **PLACE OF DEATH**
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 1 WEEK
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): POCOMOKE CITY 2342-2
d. STREET ADDRESS: 802 FOURTH STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First JOHN Middle FLETCHER Last GARDNER

4. **DATE OF DEATH**: Month AUGUST Day 6, Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 19 1893

9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BOILER ATTENDANT

10b. KIND OF BUSINESS OR INDUSTRY: CHICKEN PLANT.

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN J. GARDNER

14. MOTHER'S MAIDEN NAME: LILLIE COLONNA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 224-12-1526

INFORMANT: MRS LOLA M. GARDNER Address: POCOMOKE CITY, MARYLAND.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Bladder
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

181.0

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 7/30, 1960 to 8/6, 1960 that I last saw the deceased alive on 8/5, 1960, and that death occurred at 6:23 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James T. Estes M.D. ADDRESS (Street, city or town, state): Peninsula Gen. Hospital DATE SIGNED

PHYSICIAN'S NAME (Type): JAMES T. ESTES Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8-9-60

22c. NAME OF CEMETERY OR CREMATORY: MODESTOWN BAPTIST

22d. LOCATION (City, town, or county) (State): MODESTOWN, VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE: Robert H. Watson ADDRESS: Pocomoke City, Md.

24a. REC'D BY REGISTRAR DATE: AUG 10 '60

24b. REGISTRAR'S SIGNATURE: Clinton S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9742

CERTIFICATE OF DEATH

Reg. Dist. No. 09715

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 73 days
d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): 12 Salisbury
d. STREET ADDRESS: 617 Pearl Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES — Middle — Last HARMON

4. DATE OF DEATH: Month August — Day 22 — Year 1960

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 31, 1890

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Harmon

14. MOTHER'S MAIDEN NAME: Mary Dutton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT — Address: Ethel Quillen, 617 Pearl St, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH: 2 minutes

422.1

DUE TO
(b): Arteriosclerotic cardiovascular disease — Years

Conditions, if ony, which gove rise to immediote cause (a), stating the underlying couse lost.
DUE TO
(c): Arteriosclerosis, general — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from June 20, 1960, to August 22, 1960, that I last saw the deceased alive an Aug. 22, 1960, and that death accurred at 8:45A M, from the causes and an the date stated abave.

ACTUAL SIGNATURE: V. Juerman. M.D. — ADDRESS (Street, city or tawn, state): Deer's Head State Hospital — DATE SIGNED: 8/22/60

PHYSICIAN'S NAME (Type): V. Juerman, M. D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: August 25, 1960

22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary

22d. LOCATION (City, town, or county) (State): Fruitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Clinton F. Stewart, Salisbury, Md.

24a. REC'D BY REGISTRAR DATE: AUG 26 '60

24b. REGISTRAR'S SIGNATURE: Carlton E. Truitt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9743

09716

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082

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2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

1. **PLACE OF DEATH**
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Peninsula General Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Accomac
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural New Church
d. STREET ADDRESS: R3x-
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Augustine — Middle: — Last: Hernandez

4. **DATE OF DEATH**: Month: August — Day: 10 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/5/60

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days: 5 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Pablo Hernandez

14. MOTHER'S MAIDEN NAME: Mary Hernandez

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. **INFORMANT**: Pablo Hernandez — Address: New Church, Va.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure — 763.8
DUE TO (b): Interstitial Pneumonitis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/9 1960, to 8/10 1960, that (I) (we) last saw the deceased alive on 8/10 1960, and that death occurred at 12 ac P.M., from the causes and on the date stated above.

22a. SIGNATURE: William C. Morgan M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/10/60

22c. PHYSICIAN'S NAME (Type): William C. Morgan

22d. ADDRESS: Salesbury Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/11/60

23c. NAME OF CEMETERY OR CREMATORY: Downings Cemetery

23d. LOCATION (City, town, or county) (State): Oak Hall, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Fox Funeral Home — ADDRESS: Temperanceville, Va.

25a. REC'D BY REGISTRAR — DATE: AUG 15 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kimmey

20&2214XV5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9744

CERTIFICATE OF DEATH

Reg. Dist. No. 09718

1. **PLACE OF DEATH**
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hebron
d. STREET ADDRESS: Chestnut Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Gloria — Middle: — Last: Johnson

4. **DATE OF DEATH**: Month: August — Day: 3 — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 3, 1960

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 16 — Min.: 56

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Salisbury

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: [illegible] Johnson

14. MOTHER'S MAIDEN NAME: Gloria Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

INFORMANT: B. Johnson — Address: Hebron Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: approx 17 hours
760.5
DUE TO (b): Perinatal Hypoxia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Prematurity c Ruptured Marginal Antenatal Bleeding

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 8/3, 19 60, to 8/3, 19 60, that I last saw the deceased alive on 8/3, 19 60 and that death occurred at 11 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Alfred C Kolb M.D. — ADDRESS (Street, city or town, state): Medical Center Salisbury Maryland — DATE SIGNED: 8/3/60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-9-60

22c. NAME OF CEMETERY OR CREMATORY: Glen Hill Cem

22d. LOCATION (City, town, or county) (State): Parsonsburg Md

23. FUNERAL DIRECTOR'S SIGNATURE: Parker M West — ADDRESS: Salisbury Md.

24a. REC'D BY REGISTRAR DATE: AUG 12 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9745

CERTIFICATE OF DEATH

09719 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 HR.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
d. STREET ADDRESS: 107 ASHTON AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JOSIAH Middle: WOOLFORD Last: JOHNSON

4. DATE OF DEATH: Month: August Day: 8 Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 11-9-1873

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONTRACTOR & Designer

10b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Josiah JOHNSON

14. MOTHER'S MAIDEN NAME: MARTHA Humphreys

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 216-16-7525

INFORMANT Address: Mrs J. W. JOHNSON, SAME

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis, Acute — INTERVAL BETWEEN ONSET AND DEATH: IMMEDIATE
DUE TO
(b): Coronary Sclerosis — ?
DUE TO
(c): generalized arteriosclerosis

420.1

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8 Aug, 1960 to 8 Aug, 1960, that I last saw the deceased alive on 8 August, 1960, and that death occurred at 3:15 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robt J. AdKins M.D. ADDRESS (Street, city or town, state): FRUITLAND, MARYLAND DATE SIGNED: 8 Aug 60

PHYSICIAN'S NAME (Type): Robert AdKins FRUITLAND, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8-10-1960

22c. NAME OF CEMETERY OR CREMATORY: PARSONS Cemetery

22d. LOCATION (City, town, or county) (State): SALISBURY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hill & Johnson Co. SALISBURY, MD
Norman T. Bohen

24a. REC'D BY REGISTRAR DATE: AUG 10 '60

24b. REGISTRAR'S SIGNATURE: Arthur E. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar ta burial, cremation, ar removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9746 — 09720 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Accomack — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springhill Sanitorium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia — b. COUNTY: Accomack
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Onancock
d. STREET ADDRESS: 83X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Susie — Middle: Warren — Last: Johnson

4. DATE OF DEATH: Month: 8 — Day: 29 — Year: 1960

5. SEX: F — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: Dec. 23. 1882 — 9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months: 8 Days: 5 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher — 10b. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Pungoteague — 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John L. Warren — 14. MOTHER'S MAIDEN NAME: Sarah T. Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown): No — (If yes, give war or dates of service): — 16. SOCIAL SECURITY NO.: — 17. INFORMANT: Virginia Warren Tuckett — Address: Parksley, Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Long Duration

4208

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19 —

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-15, 1960, to 8-29, 1960, that I last saw the deceased alive on 8-29, 1960, and that death occurred at 6:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W R Ellis Jr. M.D. — ADDRESS (Street, city or town, state): Salisbury, Md. — DATE SIGNED: 8-29-60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 8/31/60 — 22c. NAME OF CEMETERY OR CREMATORY: Edgehill — 22d. LOCATION (City, town, or county) (State): Accomac Va

23. FUNERAL DIRECTOR'S SIGNATURE: J Richard Johnson — ADDRESS: Parksley, Va

24a. REC'D BY REGISTRAR — DATE: SEP 2 '60 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Heath

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9747

CERTIFICATE OF DEATH

09721

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 5 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DELMAR
d. STREET ADDRESS: 105 CHESTNUT
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ARTHUR Middle W. Last LECATES

4. DATE OF DEATH: Month AUGUST Day 9 Year 1960

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-10-1889

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONDUCTOR

10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD

11. BIRTHPLACE (State or foreign country): DELMAR

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: JOHN LECATES

14. MOTHER'S MAIDEN NAME: ALICE CALLAWAY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 716-03-6[illegible]

INFORMANT: Blanch LeCates Address: Delmar Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Pyelonephritis & Renal Failure
DUE TO (b): ____
DUE TO (c): ____

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Obstructive Emphysema with Polycythemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 6, 1960 to August 9, 1960 that I last saw the deceased alive on August 9, 1960, and that death occurred at 9:30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C. Hill Jr. M.D.
ADDRESS (Street, city or town, state): Pine Bluff Rd, Salisbury, Md.
DATE SIGNED: 8/9/60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8-11-60
22c. NAME OF CEMETERY OR CREMATORY: MT. OLIVE
22d. LOCATION (City, town, or county) (State): DELMAR - DEL

23. FUNERAL DIRECTOR'S SIGNATURE: W. S. Maull & Son
ADDRESS: Delmar, Del

24a. REC'D BY REGISTRAR DATE: AUG 11 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Keane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH

9775 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09722

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. **PLACE OF DEATH** — a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.D.# 1

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury (Rural)
   d. STREET ADDRESS: R.D.# 1
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First LEE — Middle R. — Last LIVINGSTON

4. **DATE OF DEATH**: Month AUGUST — Day 16th — Year 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: March 2,1877

9. AGE (In years last birthday): 83 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): R.D.# 1 Salisbury, Md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Benjamin Peter Livingston

14. MOTHER'S MAIDEN NAME: Martha Carey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Maurice Holloway (Daughter) R.D.# 1 (St Luke Rd) Salisbury, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 422.1 Myocardial degeneration — INTERVAL BETWEEN ONSET AND DEATH: 1 month
DUE TO
(b): generalized arteriosclerosis — ?
DUE TO
(c):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.): N/A

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year: N/A 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A

20f. (City or town) (County) (State): N/A

21. **I certify** that (I) (this hospital) attended the deceased from January 1960 to August 1960, that (I) (~~we~~) last saw the deceased alive on 12 August 1960, and that death occurred at 10:30 AM, from the causes and on the date stated above.

22a. SIGNATURE: Robert J. Adkins M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: Aug. 18 /1960

22c. PHYSICIAN'S NAME (Type): Dr. Robert Adkins

22d. ADDRESS: Fruitland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 18/1960

23c. NAME OF CEMETERY OR CREMATORY: Union Cemetery

23d. LOCATION (City, town, or county) (State): R.D.# Salisbury, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

25a. REC'D BY REGISTRAR — DATE: AUG 22 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9748

CERTIFICATE OF DEATH

09723

1. PLACE OF DEATH — a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parsonsburg (Rural)
d. STREET ADDRESS: R.D.# 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First MARGARET Middle WHITAKER Last McCULLOUGH

4. DATE OF DEATH: Month AUGUST Day 18 Year 1960

5. SEX: FEMALE
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Jan. 16, 1896
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR — Months: Days: IF UNDER 24 HRS. — Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Doctor - Physician
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Joseph J.Lawrence
14. MOTHER'S MAIDEN NAME: Nancy Dixon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Dr.Kendrick McCullough (Husband) Address: R.D.# 1 Parsonsburg, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinomal of the Lung — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
163 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Heart Disease
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year: N/A 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A
20f. (City or town) (County) (State): N/A

21. I certify that (I) (this hospital) attended the deceased from ____ 19__ to Aug 18 1960 that (I) (we) last saw the deceased alive on Aug. 18 1960 and that death occurred at 6 P.M. from the causes and on the date stated above.

22a. SIGNATURE: David J. Gilmore M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: Aug. 18, 1960
22c. PHYSICIAN'S NAME (Type): Dr.David J.Gilmore
22d. ADDRESS: Medical Center Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 24 /1960
23c. NAME OF CEMETERY OR CREMATORY: South View Cemetery
23d. LOCATION (City, town, or county) (State): Randolph, Vermont

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND
25a. REC'D BY REGISTRAR DATE: AUG 22 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9749 09724

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 9 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: VIRGINIA — b. COUNTY: ACCOMACK
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - NEW CHURCH
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JAMES — Middle PAIGE — Last MILES

4. DATE OF DEATH: Month August — Day 11 — Year 1960

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] — 8. DATE OF BIRTH: SEPT. 29, 1887 — 9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: FARMING
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: WESLEY S. MILES
14. MOTHER'S MAIDEN NAME: ANNIE TAYLOR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 231-46-3100
17. INFORMANT — Address: VERNON W. MILES, HORSEY, VIRGINIA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Undifferentiated carcinomatosis	6 mos
DUE TO (b)	Carcinoma of left colon	2 yrs
DUE TO (c)		

153.8

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 2 1960 to Aug 11 1960 that (I) (we) last saw the deceased alive on Aug 11 1960 and that death occurred at 1:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: H.A. Briele M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22b. DATE SIGNED: 8.11.60
22c. PHYSICIAN'S NAME (Type): H.A. Briele
22d. ADDRESS: Medical Center

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 8-14-60
23c. NAME OF CEMETERY ~~OR CREMATORY~~: NELSON CEMETERY
23d. LOCATION (City, town, or county) (State): RURAL - POCOMOKE CITY, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert H. Watson — ADDRESS: POCOMOKE CITY, MD.
25a. REC'D BY REGISTRAR — DATE: AUG 16 '60
25b. REGISTRAR'S SIGNATURE: Clarence S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9750 69725

CERTIFICATE OF DEATH

M

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 3 Weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: md
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: 23X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Annie — Middle: L. — Last: Mills

4. DATE OF DEATH: Month: AUGUST — Day: 11 — Year: 1960

5. SEX: FEMALE
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 25-1886
9. AGE (In years last birthday): 73 / 11 / 16
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own Home
11. BIRTHPLACE (State or foreign country): Pikesville, md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Sidney Lewis
14. MOTHER'S MAIDEN NAME: Sallie M. Niblett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-09-8046
17. INFORMANT: Mr Thornton J. Mills, Snow Hill, md — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO (b): Pulmonary Fibrosis + Emphysema — Unknown
DUE TO (c):

525X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/24 19 60 to 8/11 19 60 that (I) (we) last saw the deceased alive on 8/11 19 60, and that death occurred at 8 PM, from the causes and on the date stated above.

22a. SIGNATURE: David J. Gilmore, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/12/60
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: Medical Center, Salisbury Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 14/60
23c. NAME OF CEMETERY OR CREMATORY: Whaleyville Cemetery
23d. LOCATION (City, town, or county) (State): Snow Hill, md

24. FUNERAL DIRECTOR'S SIGNATURE: Elbert E. Dennis
ADDRESS: Snow Hill, md

25a. REC'D BY REGISTRAR: DATE AUG 15 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be performed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9751 09726

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BISHOPS
d. STREET ADDRESS 23 X-2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First James Middle F. Last MURRAY
4. DATE OF DEATH Month AUGUST Day 15 Year 1960
5. SEX MALE
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH Sept. 11 - 1905
9. AGE (In years last birthday) 54 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) DELAWARE
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME VAN MURRAY
14. MOTHER'S MAIDEN NAME NAN ESHAM

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 220-12-0437
17. INFORMANT Address MRS LILA MURRAY

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of Aortic Aneurysm — INTERVAL BETWEEN ONSET AND DEATH 3 min
DUE TO (b) Arteriosclerotic Cardiovascular disease — ?
DUE TO (c)

451 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — None.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 15 Aug. 1960 to 18 Aug 1960 that (I) (we) last saw the deceased alive on 18 Aug 1960, and that death occurred at 1/3 M, from the causes and on the date stated above.

22a. SIGNATURE Joseph C. Fitzgerald. M.D.
ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED 8/20/60
22c. PHYSICIAN'S NAME (Type) JOSEPH C. FITZGERALD
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 8/21/60
23c. NAME OF CEMETERY OR CREMATORY ODD FELLOWS
23d. LOCATION (City, town, or county) BISHOPVILLE (State) MD.

24. FUNERAL DIRECTOR'S SIGNATURE Ruben A. Bunting
ADDRESS Berlin Md.
25a. REC'D BY REGISTRAR DATE AUG 25 '60
25b. REGISTRAR'S SIGNATURE Catherine L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9776

CERTIFICATE OF DEATH

Reg. Dist. No. 09727

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parsonsburg
c. LENGTH OF STAY IN 1b: 10 Yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Rt # 2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parsonsburg
d. STREET ADDRESS: Rt #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RHODA — Middle MITCHELL — Last PARSONS

4. DATE OF DEATH: Month 8 — Day 9 — Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 22,1894

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sharp Mitchell

14. MOTHER'S MAIDEN NAME: Nettie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 217-14-8260

17. INFORMANT — Address: Mr. Ben Parsons , Parsonsbug, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): arteriosclerotic Heart Disease with failure — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bronchitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/24, 1956, to 8/1, 1960, that I last saw the deceased alive on 8/1, 1960, and that death occurred at 4:00 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ernest M Larmore M.D. — ADDRESS (Street, city or town, state): Delmar, Delaware — DATE SIGNED: 8-11-60

PHYSICIAN'S NAME (Type): Dr. Ernest M. Larmore Grove St., Delmar, Delaware

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-12-1960

22c. NAME OF CEMETERY OR CREMATORY: Farlow's Cemetery

22d. LOCATION (City, town, or county) (State): Pittsville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hill & Johnson Co. Salisbury, Maryland

24a. REC'D BY REGISTRAR DATE AUG 12 '60

24b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9752 — 09728

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 118 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Queen Anne's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Grasonville
d. STREET ADDRESS: RFD 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Dorothy — Middle: — Last: Paul

4. DATE OF DEATH: Month: Aug. — Day: 22 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-21-36

9. AGE (In years last birthday): 24 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Jacksonville Fla USA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Oliver

14. MOTHER'S MAIDEN NAME: [redacted] Fannie Potter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Deers Head Hosp.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized sarcomatosis — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

199.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 26, 1960, to August 22, 1960, that (I) (we) last saw the deceased alive on Aug. 22 1960, and that death occurred at 9:50 A.M., from the causes and on the date stated above.

22a. SIGNATURE: V. Juerman M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8/22/60

22c. PHYSICIAN'S NAME (Type): V. Juerman, M. D.

22d. ADDRESS: Deer's Head Hospital; Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8- 60
23c. NAME OF CEMETERY OR CREMATORY: Green Wood Cem
23d. LOCATION (City, town, or county) (State): Jacksonville Fla

24. FUNERAL DIRECTOR'S SIGNATURE: Booker & Wed Salisbury Md
ADDRESS:

25a. REC'D BY REGISTRAR DATE: AUG 31 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9753

09729

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen Gen Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 1 Camden Ave. Ext
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle DAVID Last PETITT

4. DATE OF DEATH: Month AUGUST Day 29th Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 22, 1874
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Snow Hill, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: David Petitt
14. MOTHER'S MAIDEN NAME: No Record

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-40-3654
17. INFORMANT: Mrs. Edna M. Petitt (Wife) Address: Camden Ave. Ext Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of prostate c metastases — INTERVAL BETWEEN ONSET AND DEATH: 2 yr.
DUE TO
(b):
DUE TO
(c):

177X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11 July 1960 to 29 August 1960, that (I) (we) last saw the deceased alive on 29 August 1960, and that death occurred at 6:40 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Robt T Adkins M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug. 30/1960
22c. PHYSICIAN'S NAME (Type): Dr. Robert T. Adkins
22d. ADDRESS: Fruitland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 1, 1960
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d. LOCATION (City, town, or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY ADDRESS: SALISBURY MARYLAND
25a. REC'D BY REGISTRAR DATE: SEP 1 '60
25b. REGISTRAR'S SIGNATURE: Carlton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 09730

9754

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 Hour
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: ~~Wicomico~~ Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Salisbury~~ Princess Anne 19X-2
d. STREET ADDRESS: Box 366 Rt.#3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby; Middle: ; Last: Pollitt

4. DATE OF DEATH: Month: 8; Day: 7; Year: 1960

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/7/60

9. AGE (In years last birthday): — yrs.
IF UNDER 1 YEAR: Months —; Days —
IF UNDER 24 HRS.: Hours 2; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME: Sidney Hayward

14. MOTHER'S MAIDEN NAME: Sylvia Pollitt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Ethel Pollitt. Address: Princess Anne, md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
762.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/7/60 6:30 PM, 19, to 8/7/60 8:45 PM, 19, that I last saw the deceased alive on ____, 19, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: B Frank Gigante M.D. ADDRESS (Street, city or town, state): 20 Prince William St DATE SIGNED: 8/9/60

PHYSICIAN'S NAME (Type): B. FRANK GIGANTI

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/8/60
22c. NAME OF CEMETERY OR CREMATORY: John Wesley
22d. LOCATION (City, town, or county) (State): Princess Anne, Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: William H. James Jr. Princess Anne, Md

24a. REC'D BY REGISTRAR DATE: AUG 11 '60

24b. REGISTRAR'S SIGNATURE: Carlton S Kines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

208 22 6393 X V 4

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9755

09731

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: since 8/11/60
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Salisbury
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Pine Bluff State Hospital
d. STREET ADDRESS: RFD # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First STELLA Middle ELIZABETH Last PRYOR

4. DATE OF DEATH: Month August Day 31 Year 19 60

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 25, 1883
9. AGE (In years lost birthday): 77 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Andrew Pollitt
14. MOTHER'S MAIDEN NAME: Mary Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT Address: Records of Pine Bluff State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 6 yrs
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gove rise to immediote couse (a), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19
20d. INJURY OCCURRED While ot work ☐ Not while ot work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 11 1960, to Aug. 31, 19 60 that (I) (xxx) last saw the deceased alive an Aug. 31 1960, and that death occurred at 7:02 p.m. the causes and an the date stated above.

22a. SIGNATURE: Edward P. Ritchings M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/31/60
22c. PHYSICIAN'S NAME (Type): Edward P. Ritchings, M.D.
22d. ADDRESS: Pine Bluff State Hospital Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-3-1960
23c. NAME OF CEMETERY OR CREMATORY: Union Church Cemetery
23d. LOCATION (City, town, or county) (State): Wicomico, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hill & Johnson Co. Salisbury, Maryland
Norman T. Baker
25a. REC'D BY REGISTRAR DATE: SEP 2 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9756 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09732

Item 2 filmG269 8-15-60 et

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
e. COUNTY: Wicomico
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): John B. Parsons Home For the Aged

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: MARYLAND b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Light Street — John B. Parsons Home For Aged
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Martha — Middle: Elizabeth — Last: Reitz

4. DATE OF DEATH: Month: Aug. — Day: 8 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Dec. 15, 1869

9. AGE (In years last birthday): 90 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: At home

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alexander Harler

14. MOTHER'S MAIDEN NAME: Nancy Long

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Records — Address: John B. Parsons Home For Aged Salisbury

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): myocardial degeneration
DUE TO (b): Arteriosclerotic heart disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: (a) years (b) years (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture pelvis - left Pubis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☑ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.): Fell

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 7-12 1960

20d. INJURY OCCURRED: While at work ☐ Not While at work ☑

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Salisbury (County) Wicomico (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earle Rogers M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

EXAMINER'S NAME (Type)

Address (Street, city, town, or county)

DATE SIGNED: 8-8-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-10-1960

22c. NAME OF CEMETERY OR CREMATORY: Charity Church Cemet.

22d. LOCATION (City, town, or country) Salisbury (State) Maryland

23. FUNERAL DIRECTOR: Thomas H. Wallace — ADDRESS: Salisbury, Md.

24a. REC'D BY REGISTRAR — DATE: AUG 11 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9757 — 09733

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 6hrs
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN OCEAN CITY 23X-2
d. STREET ADDRESS: R.F.D. The BOARDWALK
e. IS RESIDENCE ON A FARM? YES ☒ NO ☒

3. NAME OF DECEASED (Type or print): First LEO — Middle W. — Last ROSS

4. DATE OF DEATH: Month August — Day 28 — Year 1960

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JUNE 10, 1888
9. AGE (In years lost birthday): 72 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED CHEM.
10b. KIND OF BUSINESS OR INDUSTRY: DUPONT
11. BIRTHPLACE (State or foreign country): SHIPPEN TOWNSHIP Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 047-01-0353
17. INFORMANT — Address: Mrs. Leo W. Ross Ocean City, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): RUPTURE AORTIC ANEURYSM - ABDOMINAL — INTERVAL BETWEEN ONSET AND DEATH

451 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis — 15 hrs.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. — Manth, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (Caunty) (State)

21. I certify that (I) (this haspitol) attended the deceased from AUG 21 1960 to AUG 28 1960 that (I) (we) last saw the deceased alive on AUG 28 1960, and that death occurred at 1:35 PM, from the causes and on the date stated above.

22a. SIGNATURE: William B. Long M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 8/30/60
23c. NAME OF CEMETERY OR CREMATORY: EVERGREEN
23d. LOCATION (City, town, or county) (State): BERLIN MD.

24. FUNERAL DIRECTOR'S SIGNATURE: James A Burbage
ADDRESS: Berlin Md
25a. REC'D BY REGISTRAR DATE SEP 1 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09734

1 9758

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 5 MINS
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Salisbury Rt 2.
d. STREET ADDRESS: 1 Spring Hill Rd
e. IS RESIDENCE ON A FARM? YES ■ NO ☐

M

082

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: — Last: Rounds

4. DATE OF DEATH: Month: Aug. Day: 19 Year: 1960.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ■ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-10-1903

9. AGE (In years last birthday): 56 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

I

13. FATHER'S NAME: Elnsha H. Rounds

14. MOTHER'S MAIDEN NAME: Laura Powell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: Yes

17. INFORMANT: Mary E. Dykes Rounds. Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 1 Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day.

420.0

DUE TO (b): 2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Arteriosclerotic Heart Disease — 3 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

1

21. I certify that (I) (this hospital) attended the deceased from 1957 to 8/19 1960 that (I) (we) last saw the deceased alive on 8/11 1960 and that death occurred at 9:55 M, from the causes and on the date stated above.

22a. SIGNATURE: Rufus Gardner M.D. — ATTENDING PHYS. X — MED. DIRECTOR ☐ — STAFF PHYS. ☐ — 22b. DATE SIGNED: 8/19/60

22c. PHYSICIAN'S NAME (Type): Rufus S. Gardner Jr.

22d. ADDRESS: Pinehuff Rd, Salisbury, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-22-1960

23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d. LOCATION (City, town, or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Norman T. Baker — ADDRESS: Hill & Johnson Co, Salisbury, Md

25a. REC'D BY REGISTRAR DATE: AUG 23 '60

25b. REGISTRAR'S SIGNATURE: Anita L. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9759

CERTIFICATE OF DEATH

Reg. Dist. No. 09735

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Spring Hill Sanatarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wico.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 107 E. William St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NORA; Middle TULL; Last RUARK

4. DATE OF DEATH: Month 8; Day 21; Year 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12/13/1866

9. AGE (In years last birthday): 93 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Tull

14. MOTHER'S MAIDEN NAME: Laura Adams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

INFORMANT: Howard H. Ruark, same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
DUE TO
(b):
DUE TO
(c):

491X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Encephalomalacia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ___ o. m. p. m. Month ___ Day ___ Year 19___

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 22, 1958, to Aug 21, 1960 that I last saw the deceased alive on Aug 16, 1960, and that death occurred at 10 45 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C. Hill, Jr. M.D.

ADDRESS (Street, city or town, state): Pine Bluff Rd., Salisbury

DATE SIGNED: 8/23/60

PHYSICIAN'S NAME (Type): Thomas C. Hill, Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/23/1960

22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

22d. LOCATION (City, town, or county): Salisbury (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hill Johnson Co. — ADDRESS: Salisbury Md.

24a. REC'D BY REGISTRAR DATE AUG 25 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

Hill Johnson Co. Salisbury Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9760

09736

1. PLACE OF DEATH
a. COUNTY: Wicomico Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury, Md.
c. LENGTH OF STAY IN 1b: 118 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
d. STREET ADDRESS: 14X-2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: MARY; Middle: L.; Last: SMITH

4. DATE OF DEATH: Month: 8; Day: 17; Year: 1960

5. SEX: Fem...

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]

8. DATE OF BIRTH: Jan. 1-1918

9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Arthur Legg

14. MOTHER'S MAIDEN NAME: Vickers Crouch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Thomas Legg-- Rock Hall, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma of breast with generalized metastases
DUE TO (b):
DUE TO (c):

170X

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying cause lost.

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot (I) (this hospital) attended the deceosed from 4-21, 1960, to 8-17, 1960, that (I) (we) last saw the deceased alive on 8-17 1960, and that death occurred at 3:05 a.m., from the couses and on the dote stoted above.

22a. SIGNATURE: L. V. Maldve M.D.
ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]

22b. DATE SIGNED: 8-17-60

22c. PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.

22d. ADDRESS: Deer's Head State Hospital, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 19

23c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel

23d. LOCATION (City, town, or county) (State): Rock Hall, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Lane

ADDRESS: Church Hill, Md.

25a. REC'D BY REGISTRAR DATE: AUG 22 '60

25b. REGISTRAR'S SIGNATURE: Esther L. Knust

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9761 Item 7 F1mG269 8-29-60 ct

CERTIFICATE OF DEATH

09737

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1-week
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Peninsula General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. Jowson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jowson 0355-2
d. STREET ADDRESS: 13 Skidmore Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edwin Middle A. Last Snyder
4. DATE OF DEATH: Month August Day 20 Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-28-1897
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk - Recknd office
10b. KIND OF BUSINESS OR INDUSTRY: State office
11. BIRTHPLACE (State or foreign country): Balto - MD.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Adam Snyder
14. MOTHER'S MAIDEN NAME: Margaret Erlbeck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W I
16. SOCIAL SECURITY NO.: 212-14-1116
17. INFORMANT: Christine Wells Snyder Address: 13 - Skidmore ct. Tow. 4, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Central Hemorhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Cerebral Atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/16 1960, to 8/20 1960, that (I) (we) last saw the deceased alive on 8/20 1960 and that death occurred at 9:55 A.M., from the causes and on the date stated above.

22a. SIGNATURE: David J. Schumm M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-23-1960
23c. NAME OF CEMETERY OR CREMATORY: Baltimore National
23d. LOCATION (City, town, or county) (State): Frederick Rd - Balto - co MD.

24. FUNERAL DIRECTOR'S SIGNATURE: Brooks Funeral Service ADDRESS: 622 York Rd Tow-4 MD
25a. REC'D BY REGISTRAR DATE: AUG 24 '60
25b. REGISTRAR'S SIGNATURE: Clinton L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9762

CERTIFICATE OF DEATH

09739

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1903 Heathfield Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mrs. Middle Mabel R. Last Stockett

4. DATE OF DEATH: Month AUGUST Day 2 Year 1960

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
B. DATE OF BIRTH: Mar. 29, 1892
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edwin B. Harris
14. MOTHER'S MAIDEN NAME: Julia Ann Norwood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
INFORMANT: Mrs. Thomas West Address: 1903 Heathfield Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MESENTERIC VASCULAR OCCLUSION. — INTERVAL BETWEEN ONSET AND DEATH: 24 HRS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) GENARALIZED ARTERIOSCLEROSIS.
DUE TO (c)
450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2 Aug, 1960, to 2 Aug, 1960, that I last saw the deceased alive on 2 Aug, 1960, and that death occurred at 3:2 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: A. Gray Reese M.D. ADDRESS (Street, city or town, state): Medical Center, Salisbury, Md. DATE SIGNED:

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/6/60
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Leonard J. Ruck ADDRESS: 5305 Harford Road #14
24a. REC'D BY REGISTRAR DATE: AUG 5 '60
24b. REGISTRAR'S SIGNATURE: Catherine L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9763

CERTIFICATE OF DEATH

Reg. Dist. No. 09740

1. **PLACE OF DEATH**
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Peninsula General Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Fruitland
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Alfred — Middle: Ernest — Last: Strickland

4. **DATE OF DEATH**: Month: August — Day: 1 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 16-1889

9. AGE (In years last birthday): 70/13 yrs.

IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Variety Store

11. BIRTHPLACE (State or foreign country): Kelly Grange Md

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Alfred D. Strickland

14. MOTHER'S MAIDEN NAME: Effie Tilghman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War I

16. SOCIAL SECURITY NO.:

INFORMANT: Mr. Clarence W. Strickland — Address: Snow Hill, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO (b): Carcinoma of prostate — 1 year
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1777

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from April, 1960, to Aug 1, 1960, that I last saw the deceased alive on Aug 1, 1960, and that death occurred at 10:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Harry Wolfe M.D. — ADDRESS (Street, city or town, state): Salisbury, Md. — DATE SIGNED: 8/1/60

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Aug 4/60 — 22c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cemetery — 22d. LOCATION (City, town, or county): Snow Hill — (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Allen E. Dennis — ADDRESS: Snow Hill Md

24a. REC'D BY REGISTRAR — DATE: AUG 3 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9764

CERTIFICATE OF DEATH

Reg. Dist. No. 09741

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chambersburg
d. STREET ADDRESS: 762 Broad Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle Franklin — Last Texter

4. DATE OF DEATH: Month August — Day 12 — Year 19 60

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 22, 1913
9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shoe Store Mgr.
10b. KIND OF BUSINESS OR INDUSTRY: Shoe
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William L. Texter
14. MOTHER'S MAIDEN NAME: Clara J. Minium

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unkn. (If yes, give war or dates of service): -66---
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Ray Kane — Address: 250 S. 8th Street Chambersburg, Penna

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct, acute — INTERVAL BETWEEN ONSET AND DEATH: 14 days
DUE TO
(b):
DUE TO
(c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-28, 1960, to 8-12, 1960, that I last saw the deceased alive on 8-12, 1960, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William R. Ellis Jr. M.D.
ADDRESS (Street, city or town, state): Salisbury, Md.
DATE SIGNED: 8-13-60
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/16/60
22c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland Co., Penna

23. FUNERAL DIRECTOR'S SIGNATURE: Norman F. Wallace — ADDRESS: Salisbury Md
24a. REC'D BY REGISTRAR — DATE: AUG 15 '60
24b. REGISTRAR'S SIGNATURE: Cathryn S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9766

09742

CERTIFICATE OF DEATH

Item 2 Filed 9-23-60 ct

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester ~~Wicomico~~ ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Salisbury~~ X Snow Hill 23X-2
d. STREET ADDRESS: Route # 1 ~~Peninsula General Hospital~~
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Maggie; Middle:; Last: Truitt
4. DATE OF DEATH: Month: August; Day: 31; Year: 1960

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 16, 1891
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James T. Collins
14. MOTHER'S MAIDEN NAME: Mary Collins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Eben Truitt Snow Hill Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Intracerebral Hemorrhage	24 hours
DUE TO (b)	Thrombosis Right Middle Cerebral Artery	5 days
DUE TO (c)	Arteriosclerosis	

331 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 26 Aug. 1960 to 31 Aug. 1960, that (I) (we) last saw the deceased alive on 31 Aug. 1960, and that death occurred at 7:50 AM, from the causes and on the date stated above.

22a. SIGNATURE: Joseph C. Fitzgerald M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS: 707 Camden Ave.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: September 3, 1960
23c. NAME OF CEMETERY OR CREMATORY: Ebe Nezer
23d. LOCATION (City, town, or county) (State): Snow Hill Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Clinton F. Stewart
ADDRESS: Salisbury Md
25a. REC'D BY REGISTRAR DATE SEP 8 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9765 9765 09743

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 7 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): POCOMOKE CITY
d. STREET ADDRESS: 102 HICKORY ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EX Middle LEVI Last TULL

4. DATE OF DEATH: Month AUGUST Day 23 Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JANUARY 9, 1876

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: FARMING

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM TULL

14. MOTHER'S MAIDEN NAME: CATHERINE SAVAGE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 218-05-8512

17. INFORMANT: MRS VIOLA TULL, Address 102 HICKORY ST. POCOMOKE CITY, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO (b): " Arteriosclerosis
DUE TO (c):

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 17 1960 to Aug. 23, 1960, that (I) (we) last saw the deceased alive on Aug. 23 1960, and that death occurred at 11:45 M, from the causes and on the date stated above.

22a. SIGNATURE: David J. Gilmore M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/24/60

22c. PHYSICIAN'S NAME (Type): DAVID J. GILMORE

22d. ADDRESS: SALISBURY, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 8-26-60

23c. NAME OF CEMETERY OR CREMATORY: SALEM METHODIST

23d. LOCATION (City, town, or county) (State): POCOMOKE CITY, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Robert H. Watson ADDRESS: POCOMOKE CITY, MD.

25a. REC'D BY REGISTRAR DATE: AUG 29 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9767

09744

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Wicomico
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 Mo. 6 Da.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arnold
d. STREET ADDRESS: Box 575, Route 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Teresa; Middle: -----; Last: Vojtek

4. DATE OF DEATH: Month: August; Day: 5; Year: 19 60

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 16, 1878
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Unk.
11. BIRTHPLACE (State or foreign country): Czechoslovakia
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Stephen Novotny (deceased)
14. MOTHER'S MAIDEN NAME: Elizabeth ~~XXXXX~~ Mathia (deceased)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mary Engberg-dgt. Address: Hospital Records -- Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Broncho-Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 Days
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/29/ 1960, to 8/5/ 1960, that (I) (we) last saw the deceased alive on 8/5/ 19 60, and that death occurred at 4:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: H. Maldve, M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: August 5, 1960
22c. PHYSICIAN'S NAME (Type): L. Maldve, M.D.
22d. ADDRESS: Deer's Head State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug 9, 1960
23c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery, Belair Rd.
23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Schimunek Funeral Home 2601 E. Madison St
25a. REC'D BY REGISTRAR DATE AUG 9 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9768

CERTIFICATE OF DEATH

Reg. Dist. No. 10745

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Patrick Avenue, City

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 12
d. STREET ADDRESS: Patrick Avenue 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: T. — Last: Ward

4. DATE OF DEATH: Month: August — Day: 28 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: Col.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 15, 1900

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Hand

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Ward

14. MOTHER'S MAIDEN NAME: Ella Boggs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Mrs. Daisy Austin — Address: Jersey Rd, Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Broncho Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b): Pleurisy — 2 weeks
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 18, 1960 to Aug 28, 1960 that I last saw the deceased alive on Aug 27, 1960, and that death occurred at 7:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Herbert Sembly, M.D. — ADDRESS (Street, city or town, state): 400 E. Church St — DATE SIGNED: 9/1/60

PHYSICIAN'S NAME (Type): G. Herbert Sembly — Salisbury Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 31, 1960
22c. NAME OF CEMETERY OR CREMATORY: Green Acres
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Clinton F. Stewart — ADDRESS: Salisbury Md

24a. REC'D BY REGISTRAR — DATE: SEP 8 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9769 Item 7 Film G269 8-17-60 et

CERTIFICATE OF DEATH

Reg. Dist. No. 09746

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Louise — Middle: — Last: WASHINGTON

4. DATE OF DEATH: Month: AUGUST — Day: 10 — Year: 1960

5. SEX: FEMALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/15/1919

9. AGE (In years last birthday): 41 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chanber Maid

10b. KIND OF BUSINESS OR INDUSTRY: Hotel

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME: Isaac White

14. MOTHER'S MAIDEN NAME: Lucy Collier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT — Address: Isaac White. Princess Anne, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
DUE TO (b): Chronic pyelonephritis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Days / Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension C.V. Disease

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov, 1957, to 10 Aug, 1960, that I last saw the deceased alive on 10 Aug, 1960, and that death occurred at 12 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl L Royster — M.D. — ADDRESS (Street, city or town, state): 407 Camden Ave Salisbury Md — DATE SIGNED: 8-11-60

PHYSICIAN'S NAME (Type): Earl L Royster

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/14/60

22c. NAME OF CEMETERY OR CREMATORY: St Paul

22d. LOCATION (City, town, or county) (State): Revell Neck Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: William H. James Jr Princess Anne, Md

24a. REC'D BY REGISTRAR DATE: AUG 15 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09747

9770

CERTIFICATE OF DEATH

Item 2 Film0271 9-15-60 et

1. PLACE OF DEATH
a. COUNTY: Wicomico County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury, Md.
c. LENGTH OF STAY IN 1b: 14 months
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: 22. Maryland
b. COUNTY: Worcester /Wicomico/
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12. Salisbury, Md. Pocomoke City
d. STREET ADDRESS: ////////// Nursing Home RFD # 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MOLLIE — Middle W. — Lost WATERMAN

4. DATE OF DEATH: Month 8 — Day 30 — Year 19 60

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb., 1878

9. AGE (In yeors last birthday): 82 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Ward

14. MOTHER'S MAIDEN NAME: Elizabeth Tull

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: ---

17. INFORMANT: Mrs Mary Outten, Address 302 E. Isabella St. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 6 days.
DUE TO (b):
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse lost. DUE TO (c):

491X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot (I) (this hospital) attended the deceased from 6-10 19 59 to 8-30 19 60, thot (I) (we) last saw the deceased olive on 8-30 19 60 and that death occurred at 3:35 p.m., from the couses ond on the dote stated obave.

22a. SIGNATURE: L. V. Maldve, M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 8-31-60

22c. PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.

22d. ADDRESS: Deer's Head State Hospital Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-3-60

23c. NAME OF CEMETERY: Forest Lawn

23d. LOCATION (City, town, or county) (State): Norfolk, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Robert H. Watson
ADDRESS: Pocomoke City, Md.

25a. REC'D BY REGISTRAR DATE SEP 6 '60

25b. REGISTRAR'S SIGNATURE: Charles S. Knox

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9777

CERTIFICATE OF DEATH

09748 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mardella Springs
c. LENGTH OF STAY IN 1b: 10 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Maple Shade Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
d. STREET ADDRESS: 22 Muir street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

0913-2

3. NAME OF DECEASED (Type or print): First Charles — Middle Richard — Last Willey

4. DATE OF DEATH: Month August — Day 9 — Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 28, 1875
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired House Painter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Dorchester County
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Richard C. Willey
14. MOTHER'S MAIDEN NAME: Elizabeth Barber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT Address: Mrs. Howard Hubbard, 13 Cemetery Ave., Cambridge

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart — INTERVAL BETWEEN ONSET AND DEATH: 2 years
420.0
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 15, 1960, to Aug 8, 1960 that I last saw the deceased alive on Aug 8, 1960, and that death occurred at 6A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: H. S. Kuhlman M.D. ADDRESS (Street, city or town, state): Preston, Md. DATE SIGNED: 8/10/60
PHYSICIAN'S NAME (Type): H. S. Kuhlman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 11, 1960
22c. NAME OF CEMETERY OR CREMATORY: Dorchester Memorial Park
22d. LOCATION (City, town, or county) (State): Cambridge, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth R. Thomas
ADDRESS: Cambridge, Md.
24a. REC'D BY REGISTRAR DATE: AUG 15 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B